Office Use Only

Patient # ____________

Doctor # ____________

Today's Date ____________

Patient Information Sheet

Women's Health Alliance, P.A.

pka

Wilkerson Obstetrics & Gynecology
Raleigh, N. C. 27607

Please Print

Name: ______________________________ Age: ______ Date of Birth ___/___/______

First Middle Maiden Last M D YEAR

☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Street Address: (not a P.O. Box) ______________________________

Street Apt#

City: ____________ State: ________ Zip Code: ______ Email: ____________

Telephone: ____________ Cell Phone: ____________

Employer's Name & Address: ______________________________ Telephone: ____________

SS# ____________ Type of Work: ____________

Emergency Contact Name ____________ Phone ____________ Relationship ____________

Pharmacy Name: ____________ Address ____________ Phone: ____________

Spouse's/Guardian/Parent's Name: ______________________________

Spouse's Employer: ______________________________ Spouse's Work Phone: ____________

Spouse's SS #: ______________________________ Date of Birth ____________

Who referred you to this office? (Name and address if doctor) ______________________________

Payment is due at time service is rendered:

I plan to make payment of my medical expenses as follows: (check one or more)

☐ Cash / Check ☐ Medicare ☐ Master Card / Visa

Please list your Insurance Carrier(s). We file insurance for State Health Plan, Blue Cross and Blue Shield (BCBS), Medicare, and various HMO insurance plans. We do not file for any other insurance companies except for obstetrical and surgical patients. If you have other insurance, you may file yourself with the receipt given to you when you check out. Just attach this receipt to your insurance form and file.

Primary Insurance: ______________________________ Cert#: ____________ Policy #: ____________

Policyholder's Name: ______________________________ Relationship to Patient: ____________

Secondary Insurance ______________________________ Cert#: ____________ Policy #: ____________

Policyholder's Name: ______________________________ Relationship to Patient: ____________

Financial Agreement and Authorization for Treatment:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges promptly upon presentment thereof.

It is agreed that payments will not be delayed or withheld because of insurance coverage or the pendency of claims theron, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof.

Insurance payments are based on what insurance companies consider usual and customary. Oftentimes insurance payments are not 100% of fees charged. I understand that I am responsible for any copays, co-insurance and / or deductibles.

I authorize the release of any medical information necessary to process insurance claims.

Signature: ______________________________ Date: ____________